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Notice of Independent Review Decision

DATE: August 27, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI Cervical Spine Repeat

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified by the American Board of Occupational Medicine with over 34 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
11/10/10: Cervical Spine Series – Five Views report interpreted by with
03/04/11: MRI Cervical Spine without Contrast report interpreted by with
05/23/11: EMG and Nerve Conduction Report by with
07/13/11: Operative Report by with
09/09/11: Peer Review by
11/05/11: Designated Doctor Exam by
11/15/11: Independent Review Decision by with
01/03/12: Progress Notes from
01/18/12: Office Visit by with
01/19/12: Office Visit by with
01/26/12: Consultation Request from with
01/26/12, 02/23/12, 03/22/12, 04/19/12, 05/21/12, 06/21/12: Progress Notes from
04/18/12: Decision and Order by with
06/21/12: Utilization Review Referral from
06/27/12: UR performed by
07/20/12: Progress Notes from
07/23/12: UR performed by

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who sustained a work-related injury when she grabbed a railing while slipping on a wet floor and falling. She is status post left shoulder surgery.

11/10/10: Cervical Spine Series – Five Views report interpreted by with. IMPRESSION: Severe muscle spasm.
03/04/11: MRI Cervical Spine without Contrast report interpreted by with. CONCLUSION: C5-C6 right preforaminal focal small disc protrusion or small extrusion abutting the right peripheral ventral cord and possibly encroaching on right C6 exiting root and ventral C7 root. This is opposite the side of the patient's left shoulder pain. Straightened lordosis with localized reversal at C5-C6. The remainder of the cervical levels show no compressive disease.
05/23/11: EMG and Nerve Conduction Report by with. IMPRESSION: These electromyogram and nerve conduction studies of the left upper limb were within normal limits.
07/13/11: Operative Report by with. Postoperative Diagnoses: Left shoulder intratendinous full-thickness rotator cuff tear. Left shoulder extensive glenohumeral joint synovitis associated with anterior labral tear with partial-thickness intra-articular subscapularis tendon tear. Impingement syndrome, left shoulder. Hypertrophic changes of acromioclavicular joint resected region with internal derangement creating medial outlet stenosis. PROCEDURES PERFORMED: Left shoulder arthroscopic rotator cuff repair. Left shoulder arthroscopy with debridement, extensive, including labral debridement, synovectomy, and debridement of intra-articular partial-thickness subscapularis tendon tear. Arthroscopic subacromial decompression. Arthroscopic distal clavicular excision.
09/09/11: Peer Review by. The compensable injury and diagnosis is bilateral knee contusion, soft tissue myofascial strain of the paravertebral musculature of the cervical spine, strain of the left shoulder, and strain of the left wrist. The claimant only complains now of headaches, and the claimant had no improvement with the epidural steroid injection. The claimant has had prior physical therapy and is capable of continuing a home based exercise program and over-the-counter anti-inflammatory and/or analgesic medication as needed for symptoms. No further referrals to specialists, invasive testing, durable medical equipment, formal physical therapy, chiropractic care, physician office visits, surgery, work hardening or work conditioning, chronic pain management programs, individual psychological counseling, prescriptive medications, or injections are indicated for the cervical spine.
11/05/11: Designated Doctor Exam by. DIAGNOSES: Cervical flexion-extension, neck sprain. Lumbar sprain. Sprain other spec sites of shoulder/upper arm. This lady is neurologically intact in the cervical and lumbar spine with symmetrical reflexes, strength and sensation in the bilateral upper and lower extremities. The MRI studies of those areas reported chronic changes with no acute findings. The EMG of the upper extremities was normal with no radiculopathy. Examination today shows mild signs of rotator cuff tendonitis that are consistent with the history of previous surgery and with the MRI that followed this injury. The surgery report noted extensive findings that are not correlated with the MRI or with the current examination. It is my opinion that the current injury does not include tears in the rotator cuff. There are no objective findings of radiculopathy, neuropathy, or other neurogenic injury in either the upper or the lower extremities. There is no atrophy in the upper or lower extremities.
11/15/11: Independent Review Decision by with. EXPLANATION OF THE DECISION: Based on the records provided, there is not much in the way of objective findings to justify performing ACDF at C5-C6. The MRI showed C5-C6 right preforaminal focal small disc or small extrusion abutting the right peripheral ventral cord and possibly

encroaching on the right C6 exiting root and ventral C7 root. This is opposite the side of claimant's left shoulder pain. Straightened lordosis with localized reversal at C5C6. The remainder of the cervical levels show no compressive disease. Her EMG was normal. On exam, there are vague findings of weakness. There are no pathological reflexes. Therefore, the request for inpatient Cervical ACDF C6-C6, LOS x 1 is not reasonable or medically necessary.

01/03/12: The claimant was evaluated by with with complaints of left shoulder pain. It was noted that she continued to have neck pain and shoulder pain. She stated that she was unable to grip for very long with either hand. It was noted that Elavil was not working, which the claimant stated kept her up and increased her heart rate. On examination, she had neck pain with upward and downward ROM. She had tenderness to palpation over the cervical spine musculature and decreased ROM in the bilateral shoulders. Hand grips were weak but equal bilaterally. PLAN: Discussed DC Elavil; taper down as discussed. Continue with second opinion. Continue PT exercises as directed. Continue sedentary work through 01/09/12. Return to clinic in one month. Obtain pain meds through.

01/18/12: The claimant was evaluated by who noted that her second opinion had been denied secondary to an MRI scan. On physical exam, she had decreased range of motion in the cervical spine at about 20 degrees of rotation to the left and 35 degrees to the right side. Negative Spurling's sign. She had paraspinal spasm to examination, decreased in extension. She had no hyperreflexia or clonus on physical exam. No atrophy of her musculature. She did exhibit some give-way weakness of her triceps on the right side. ASSESSMENT/RECOMMENDATIONS: In my opinion, I would send for another MRI scan because I cannot explain why she has a failure to thrive with respect to her cervical spine. In her low back, she has degenerative disc disease and she has aggravated that. I told her that I cannot do anything for that. She strained her back and she does not need surgery for her low back, she needs some possible facet injections or some pain management, some weight loss and some physical conditioning for her low back. She has no neurological deficits. I will see her back in this clinic after the worker's compensation carrier has approved scheduling a repeat MRI scan and second opinion. I think her pain is coming from her work related injury. I do not think she is at maximum medical improvement.

01/19/12: The claimant was seen in follow-up by. On Physical exam, she had a decidedly positive Spurling's sign with extension and lateral bending to the left. She was tender at Erb's point. Well-healed arthroscopic portal sites were noted about the left shoulder. Rotator cuff weakness was noted. She elevated to 150 degrees, external rotation to 45 degrees. PLAN: At this time, she continues to have problems with the cervical spine. I would agree with that her symptoms are emanating from the neck region. He has suggested operative intervention. At this time, she has not reached maximal medical improvement. I would again include in her injured regions the cervical spine and the left shoulder. I would not plan at this point any active treatment for the shoulder other than continued range of motion exercises because she still is requiring further intervention for her neck. Until this is undertaken, I do not feel she will be able to return to her regular work activity. Hopeful the carrier will reconsider further treatment for the cervical spine.

01/26/12, 02/23/12, 03/22/12, 04/19/12, 05/21/12, 06/21/12: The claimant presented to and was evaluated by. On 02/23/12, physical exam revealed tenderness with palpation of the neck and pain with range of motion. On 03/22/12, the claimant complained of

neck and shoulder pain, worse now. She stated that she was doing home exercises. It was noted that she had increased pain radiating to shoulder blade and down the right arm with numbness in the right arm/hand. On physical exam, grip was slightly weak, right greater than left. She was given a prescription for a Lidoderm patch 5% #30. On 04/19/12, she was given a prescription for Lortab 7.5 mg #60 and Flexeril 10 mg #30. On 05/21/12, she complained of bilateral shoulder pain and neck pain. On examination, she had tenderness with palpation across the cervical paraspinal muscles. Hand grips were strong and equal bilaterally. She had increased neck pain with range of motion. She was given a prescription for Norco 7.5/325 mg #60. On 06/21/12, the claimant complained of pain all over. She complained of bilateral hand numbness, right greater than left, and stated that she "still dropped stuff." On physical exam, she had weak grip strength. She was tender with palpation to the cervical paraspinal muscles. She had a steady gait.

04/18/12: Decision and Order by with. DECISION: The compensable injury of 11/09/10 does not extend to include a herniated disc at C5-C6 and a left shoulder rotator cuff tear with extensive glenohumeral synovitis and an anterior labral tear.

06/21/12: Utilization Review Referral from. DESCRIPTION: MRI C-Spine. MISCELLANEOUS INFORMATION: Patient is being referred to a neurosurgeon. They require a current MRI before scheduling the patient.

06/27/12: UR performed by. REVIEWER COMMENTS: This is a request for a repeat cervical MRI in a patient presenting with neck pain. The patient's neck pain has been present since 2011 and was evaluated with a cervical MRI demonstrating a C5-C6 right small focal disc protrusion. As per medical report dated 06/22/12, the patient complains of bilateral shoulder pain and neck pain. There is also a note of bilateral hand numbness, right more than left, noting "still drop stuff." Objective findings include tenderness with palpation of the cervical paraspinal muscles, thoracic to lumbar spine. There was no noted comprehensive neurologic examination of the cervical spine which included sensation, muscle strength and reflexes. The clinical information provided for this review did not demonstrate a progression of the patient's condition or presence of neurologic signs or deficits. Supplement reports to show failed conservative treatment for the neck through physical therapy reports were not submitted. As such, the medical necessity of the requested service has not been substantiated. ADDENDUM: I received a call from. She stated the orthopedic surgeon requested a repeat MRI because the neurosurgeon will not see the patient without an updated cervical MRI. On physical examination, there was bilateral hand weakness, which was a change from the January exam. The January exam revealed unilateral hand weakness. However, the medical necessity still has not been substantiated based on the reasons stated above. Determination: Unchanged.

07/20/12: The claimant was reevaluated by. She stated that her right hand/arm would become numb more quickly than in the past and that she was "still dropping things." She stated that she continued to have numbness in the left hand/arm and "pinching" to the neck with "shock sensation down both arms." On examination, she had tenderness with palpation over the cervical paraspinal muscles. She had limited ROM with pain in the neck. She had bilateral hand grip weakness.

07/23/12: UR performed by. REVIEWER COMMENTS: This is an appeal for repeat cervical MRI. The request was previously denied due to lack of a comprehensive neurologic examination of the cervical spine and upper extremities including sensation, muscle strength and reflexes. There was also lack of documentation of progression of

the patient's condition or neurologic deficits. There were no supplemental reports to indicate failure of conservative treatment for the neck including physical therapy reports. Updated documentation included PT records from 11/2010 to 9/2011 noting that the patient had good response to rehabilitative interventions directed at the neck, left shoulder, and low back. There was still no comprehensive documentation of the patient's current neurologic findings indicating significant changes in symptoms or motor-sensory deficits that would justify the need for repeat MRI. It was discussed with Ms. McMahon that prior MRI showed herniation, but EMG was normal. There is no documentation of the interval clinical change that would warrant repeat study, and she did not have additional rationale. Based on these grounds, the medical necessity of this request has not been substantiated, and the previous non-certification is upheld.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse decisions are upheld. The claimant is a female who sustained a work-related injury when she grabbed a railing while slipping on a wet floor and falling on xx/xx/xx. An initial Cervical Spine MRI done on 03/04/2011 was read as follows: "C5-C6 right preforaminal focal small disc protrusion or small extrusion abutting the right peripheral ventral cord and possibly encroaching on right C6 exiting root and ventral C7 root. This is opposite the side of the patient's left shoulder pain. Straightened lordosis with localized reversal at C5-C6. The remainder of the cervical levels show no compressive disease." She went on to have arthroscopic rotator cuff repair of the left shoulder but cervical pain continued. An EMG done as follow up to imaging did not demonstrate radiculopathy. Although there is no documented neurologic examination of the cervical spine and upper extremities including sensation, muscle strength or documentation of progression of the claimant's condition or neurologic deficits, the initial MRI has pathology that could explain her current symptoms. Therapy records from 11/2010 to 9/2011 show that the claimant had good response to treatments for the neck, left shoulder, and low back. However, there was still no documentation of the claimant's current neurologic findings indicating significant changes in motor-sensory deficits that would justify the need for repeat MRI. The ODG specifically states that significant interval change needs to be documented to justify repeat imaging. Insufficient documentation of change in clinical status does not support medical necessity of this request for MRI Cervical Spine Repeat, and the previous non-certification is upheld. Furthermore redundant testing would not add value to the case or to the diagnosis.

ODG:

Magnetic resonance imaging (MRI)	Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria™. MRI imaging studies are valuable when physiologic evidence indicates

	tissue insult or nerve impairment or potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Bey, 1998) (Volle, 2001) (Singh, 2001) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) **Indications for imaging -- MRI (magnetic resonance imaging):** - Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present - Neck pain with radiculopathy if severe or progressive neurologic deficit - Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present - Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present - Chronic neck pain, radiographs show bone or disc margin destruction - Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal" - Known cervical spine trauma: equivocal or positive plain films with neurological deficit - Upper back/thoracic spine trauma with neurological deficit

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)